Agency:	**107 Health Care Authority**
Decision Package Code/Title:	**ML2-FD Increase Funding for OAH**
Budget Period:	**2015-17 Biennial Submittal**
Budget Level:	**ML2 – Maintenance Level 2**

Recommendation Summary Text

The Health Care Authority (HCA) requests $2,520,000 ($1,312,000 GF-State) in the 2015-17 biennium to fund administrative hearings and the Office of Administrative Hearings (OAH) expenses for medical assistance caseloads.

Package Description

The HCA requests $2,520,000 ($1,312,000 GF-State) to adjust the central services model and manage new, significant increases in the number of administrative hearings on behalf of those applicants and recipients appealing decisions made by the HCA.

Pursuant to state law RCW 74.09.741 and federal law 42 CFR 431.200-246, the HCA is required to offer administrative hearings to applicants and recipients of Medicaid (including its waivered programs) and the Children's Health Insurance Program (CHIP). Medicaid law requires hearings to be completed within 90 days. The HCA and the OAH must coordinate their activities in the implementation of the hearing requirement. Currently, there is a backlog of hearings in the Modified Adjusted Gross Income (MAGI) and Medicaid Personal Care (MPC) programs due, in part, to lack of funding. The HCA contracts with the OAH to provide Administrative Law Judges (ALJ) to conduct these hearings, issue timely and fair hearing decisions and ensure that the HCA's clients receive due process under the law. The HCA must maintain a hearing system in compliance with our federal funding source or risk loss of federal participation in the Medicaid program and costly litigation. However, the HCA does not currently have enough funds to cover the existing hearings caseload at the OAH.

The 2013-15 biennium HCA budget request for $3.8M that was needed to cover the OAH expenses was not fully funded; only one-half of that amount was funded. Given the amount funded in the 2013-15 biennium, the Authority's monthly spending exceeds the allotted funding 52 percent, causing the HCA to be significantly overspent. Therefore, we will need a projected $1,260,000 to fully fund the 2013-15 biennium.

The increase is driven by the expansion of the Medicaid program, the reinstitution of the Adult Dental program, and other areas. Overall, the number of hours the HCA has paid to the OAH has increased by 11 percent when comparing the first eight months to the last four months of fiscal year 2014. For example, the MAGI Medicaid caseload for the OAH increased from zero OAH billed judge hours in October 2013 to 135.3 OAH billed judge hours per month in both May and June 2014. The Medical, Dental, Transportation, Equipment (MDTE) hearing hours increased by more than 25 percent per month when comparing the first eight months to the last four months of fiscal year 2014. The table below depicts the monthly ALJ hours in fiscal year 2014 along with invoices paid at $120 per hour to the OAH.

Judge Time & Invoices Paid by Month - FY14

	Jul 2013	Aug 2013	Sept 2013	Oct 2013	Nov 2013	Dec 2013	Jan 2014	Feb 2014	Mar 2014	Apr 2014	May 2014	Jun 2014
Hrs	1,150.9	1,137.6	1,176.7	1,494.7	1,045.9	1,059.7	1,193.4	1,050.8	1,122.0	1,340.4	1,331.7	1,371.7
Invoice	$138,108	$136,506	$141,204	$179,364	$125,506	$127,162	$143,208	$126,108	$134,640	$160,848	$159,804	$164,604

The increase in hearing requests was the result of an implementation problem that was created at the time of the Affordable Care Act (ACA) implementation. Fair hearing request forms were being sent with every notification packet. The wording of the form caused many MAGI applicants to inadvertently request hearings for situations that cannot be addressed through the appeal process. This form is causing similar problems for the Health Benefits Exchange (HBE). The problem is such that even while a majority of the MAGI enrollees are approved and have no negative action by the HCA, they are completing and returning the hearing request form. Many of these applicants are Limited English Proficiency (LEP) enrollees. Eighty-nine percent of these requests get withdrawn but still requires a significant and costly amount of up-front work and must result in a written (not oral) appeal withdrawal from the enrollee. The remaining 11 percent that end up going to hearing because either they didn't understand and they have no grievance with any actions taken, either withdraw while present at the hearing or they just don't show up for the hearing (default). In some cases, appeals are filed for applicant experiences that are not judiciable through a hearing, such as dissatisfaction with the HBE website.

In an effort to reduce the cost to the state, the HCA, the Department of Social and Health Services (DSHS) and the OAH are developing an expedited process that recognizes the very high default rates for these MAGI hearings. Hearings will be scheduled in 10-case batches per half hour through the day to try and keep up.

Since October 2013, Medical Eligibility Determination (MEDS) has received 6,725 requests for hearings and continues to receive approximately 450 hearing requests per week. The fair hearing request form is slated to be removed from circulation in the spring of 2015. All efforts to get it pulled sooner have not been successful due to programming requirements and an enormous backlog of hearings has ensued. Until the form is pulled in the spring of 2015, the number of hearings will remain high, estimated to be around 2,000 per month and there will be increased workload as the HCA and the OAH work through the backlogs.

Prospectively, the HCA will begin implementing a required verification of the MAGI applicant attestations of qualifying information that will likely generate substantial increases in the number of appeals that are very likely to go through to a full hearing. To date, there were approximately 1,114,800 new MAGI applicants during fiscal year 2014 that would be subject to these reviews and the process and benefit effects cannot yet be forecast. The HCA anticipates beginning case reviews of the MAGI applicants on September 1, 2014 with 70 staff completing approximately 14,000 reviews per month. The HCA anticipates at least 30 percent of those reviews will result in negative actions, or 4,200 per month. Historically, 20 percent of those applicants with negative actions ask for a hearing, therefore, the HCA assumes the number of hearing requests will be 840 per month. The HCA believes 80 percent will be resolved in early resolution, leaving 168 cases per month being heard by a judge at 1.5 hours each.

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Because of the two process changes, the HCA will update this request for funding when further data is available subsequent to the implementation of the changes to the appeal forms and verification process and data becomes available to assess the impacts.

Questions related to this request should be directed to Cari Tikka at (360) 725-1181 or at Cari.Tikka@hca.wa.gov .

Fiscal Detail/Objects of Expenditure

	FY 2016	FY 2017	Total
1. Operating Expenditures:			
Fund 001-1 GF-State	$ 656,000	$ 656,000	$ 1,312,000
Fund 001-C GF-Federal Medicaid Title XIX	$ 604,000	$ 604,000	$ 1,208,000
Total	**$ 1,260,000**	**$ 1,260,000**	**$ 2,520,000**

	FY 2016	FY 2017	Total
2. Staffing:			
Total FTEs	-	-	-

	FY 2016	FY 2017	Total
3. Objects of Expenditure:			
A - Salaries And Wages	$ -	$ -	$ -
B - Employee Benefits	$ -	$ -	$ -
C - Personal Service Contracts	$ -	$ -	$ -
E - Goods And Services	$ 1,260,000	$ 1,260,000	$ 2,520,000
G - Travel	$ -	$ -	$ -
J - Capital Outlays	$ -	$ -	$ -
N - Grants, Benefits & Client Services	$ -	$ -	$ -
Other (specify) -	$ -	$ -	$ -
Total	**$ 1,260,000**	**$ 1,260,000**	**$ 2,520,000**

	FY 2016	FY 2017	Total
4. Revenue:			
Fund 001-C GF-Federal Medicaid Title XIX	$ 604,000	$ 604,000	$ 1,208,000
Total	**$ 604,000**	**$ 604,000**	**$ 1,208,000**

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Narrative Justification and Impact Statement

What specific performance outcomes does the agency expect?

This request is critical to sustain the HCA's administrative hearings process. Insufficient funding will have major fiscal implications for the state. The HCA will become extremely limited in the capacity to perform essential requirements of the Medicaid Act and all implementing regulations promulgated by the Department of Health and Human Services (HHS).

1. Background - Medicaid is a cooperative federal-state entitlement program that assists the poor in meeting the cost of necessary medical services.[1] Federal law requires that Medicaid agencies allow a "fair hearing" to any individual whose request for assistance is denied or is not acted upon with "reasonable promptness."[2] Federal law requires that the state's hearing system meet the due process standards set forth in *Goldbery v. Kelly*, 397 US 254 (1970). Federal law requires that the agency "ordinarily" must take final action on appeals within 90 days of the request.[3] In 2012, the United States Court of Appeals for the Second Circuit found that failure to meet the federal timeliness standard creates a right enforceable under 42 U.S.C. §1983.[4]

2. The HCA needs additional funds to cover existing workload at the OAH – the HCA contracts with the OAH to provide ALJs to conduct hearings and provide support staff to schedule hearings. The HCA pays the OAH a fully burdened rate of $120 per ALJ hour.[5] According to the hearings data maintained by the OAH, the forecasted OAH expenditure using the fully burdened rate model in fiscal year 15 is $1,872,000 per year. The current central service model funds $1,208,000 per year, a deficit of $344,000 GF-State and $317,000 GF-Federal annually.

3. Improved Timeliness – Due process standards are not being achieved. In an effort to meet the federal timeliness requirement referenced above, the HCA and the OAH agreed to certain performance goals in the Interagency Agreement between the HCA and the OAH. The HCA received the first of these reports for June 2014. One goal was that prehearing conferences were to occur within 21 calendar days of the date of the request for hearing and the actual hearings were to be schedule to occur within 45 calendar days of the date of the request for hearing. The OAH only met this requirement 14.5 percent of the time in June 2014. A second goal was that the notices of hearing or prehearing conference would be mailed within four business days of the OAH's receipt of the request for hearing. The OAH only met this goal 26.8 percent of the time in June 2014. A third goal was that all dispositive orders would be mailed within three business days of receiving a withdrawal request or the appellant's failure to appear at a hearing. The OAH only met this requirement 67.2 percent of the time in June 2014. A fourth goal was that Initial Orders would be

[1] 42 USC §1369.
[2] See Soc. Sec. Act §1902(a)(3)
[3] 42 CFR §431.244(f)
[4] See *Shakhnes v. Berlin*, 689 F3d 244, 254 (2d Cir 2012)
[5] During SFY13, OAH used a different rate varying from $98 per ALJ hours plus $55 per support staff hour and $76.74 per ALJ hour and $47.63 per support staff hour. This fully-burdened rate became effective in SFY14 and there is no direct charge for support time.

mailed within 18 calendar days after closure of the hearing record. The OAH only met this requirement 78.2 percent of time in June 2014.

In addition, there is an enormous backlog of hearings in MAGI and MPC programs. The HCA continues to monitor and evaluate administrative hearings and the OAH expenses for medical assistance caseloads by means of lean techniques in order to improve upon current timeliness performance. The HCA, the DSHS and the OAH are developing an expedited process that recognizes the default rates for MAGI hearings and will schedule 10-case batches per half hour through the day to improve timeliness.

Performance Measure Detail
Activity Inventory
H015 HCA Payments to Other Agencies

Is this decision package essential to implement a strategy identified in the agency's strategic plan?
The mission of the HCA is to provide high quality health care for the state's most vulnerable residents. The HCA cannot have a Medicaid program without allowing for a fair hearing process that complies with state and federal law.

Does this decision package provide essential support to one or more of the Governor's Results Washington priorities?
This request supports Governor Inslee's Results Washington Goal 5: Effective, Efficient and Accountable government – Customer Satisfaction, Cost Effective Government, and Transparent & Accountable. Within the division of Legal and Administrative Services, the Office of Legal Affairs records data related to the timeliness of the hearings and appeals processes related to the HCA's medical assistance programs. Tracking the timeliness of the hearings and appeals processes helps the HCA ensure access to justice and timely adjudication of appeals for our Medicaid applicants and recipients. The hearing process should typically be completed within 90 days of the date the appeal was received according to 42 CFR 431.244(f).

What are the other important connections or impacts related to this proposal?
The HCA has no option but to employ the OAH's administrative hearings services in responding to those applicants appealing decisions made by the HCA. In doing so, other important activities will be de-prioritized, such as effectively administering coordinated health care, with quality results, at the lowest cost.

The OAH supports this request and has also submitted a decision package, and is concerned about the increased risk of costly litigation and loss of federal participation due to non-compliance of timely adjudication of appeals for Medicaid applicants and recipients.

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What alternatives were explored by the agency, and why was this alternative chosen?
There are no statutory, regulatory, or other changes or negotiation possibilities that would reduce the necessity of providing administrative hearings initiated on behalf of those appealing decisions made by the HCA.

The HCA's Office of Legal Affairs represents the state's interest in ensuring that clients receive due process under the law while promoting the integrity of the HCA's various programs, which includes protecting the appropriate use of taxpayer money for covered health services. The HCA has worked closely with the OAH in considering alternatives and has determined that the current OAH administrative hearing process offers the most cost-effective, timely and fair approach to meet the HCA's constitutional and statutory requirement for entitlement programs. The HCA will continue to explore other ways to offer timely and cost effective hearings.

What are the consequences of adopting this package?
If funded, the state will be able to cost-effectively obtain administrative hearings on behalf of those appealing decisions made by the HCA. Adhering to the timeliness requirements will avert potential litigation and loss of federal participation in the Medicaid program. A recent decision from the U.S. Court of Appeals for the Second Circuit (*Shakhnes v. Berlin*, 689 F3d 244, 254 (2d Cir 2012)) ruled that failure to meet the federal timely standard creates a right enforceable under 42 U.S.C. § 1983.

What is the relationship, if any, to the state capital budget?
None

What changes would be required to existing statutes, rules, or contracts, to implement the change?
None

Expenditure and Revenue Calculations and Assumptions

Revenue Calculations and Assumptions:
The HCA assumes that the additional funding requested will be eligible for federal Medicaid match funding equal to 52 percent of the total cost.

Expenditure Calculations and Assumptions:
The HCA has experienced considerable growth of its Medicaid population, increasing the number of hearings requested. The number of hours the HCA has paid to the OAH has increased by 11 percent when comparing the first eight months to the last four months of fiscal year 2014.

Which costs, savings, and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?
Distinction between one-time and ongoing costs:
All costs identified in this package are ongoing. The HCA will continue to monitor its hearings caseload to ensure that its staffing levels are appropriate.

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Budget impacts in future biennia:
The OAH legal services will be required for the HCA into the foreseeable future. The funding needed for upcoming biennia will be determined based on prior expenditures and payment data related to the HCA cases.